

Health Insurance Plans Summary

Health Insurance Plans	Insure MT Premier Plan	Insure MT Standard Plan	Montana State Employee	SEIU 775 Plan D Premiera PPO Plan	SEIU 775 Plan B Premiera PPO Plan	Allegiance	New West Illustrative Quote
Lifetime Max Benefit	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Deductible	\$750 Individual \$1,500 Family	\$1,5000 individual \$3,000 Family	\$550 individual \$1,650 family	<u>In-network:</u> \$100 Ind / \$300 family <u>Out-of-network:</u> \$300 Ind / \$900 family	<u>In-network:</u> \$0 <u>Out-of-network:</u> \$300 Ind / \$900 family	<u>PPO:</u> \$750-1,500 Individual Family- Two times deductible per insured <u>Non PPO:</u> Same as PPO	\$1,000 Individual \$3,000 Family
Deductible waived for:	In and out of state PPP services, preventive health services (with PPP), well-child care (birth-7), mammograms, hospice, home health, routine newborn services, diabetic education benefit	In and out of state PPP services, preventive health services (with PPP), well-child care (birth-7), mammograms, hospice, home health, routine newborn services, diabetic education benefit	First two non-routine office visits, routine newborn services, preventive adult exams and tests, adult immunizations, allergy shots, child checkups and immunizations	In-network: Preventive care Prescription drugs Screening Mammography Out-of-network: none	In-network: Preventive care Prescription drugs Screening Mammography Out-of-network: none	Mammograms, routine outpatient well-child care (0-7), routine prostate specific antigen test.	\$600 Accident Benefit, \$300 Voluntary Sterilization, Preventive health services, well-child care (birth-17), mammograms, routine newborn services, diabetic education benefit
Coinsurance	Plan pays 75% of allowable fee Member pays 25%	Plan pays 60% of allowable fee Member pays 40%	General 75% Preferred facility services 80% Non-preferred facility services 65%	In-network: 80% Out-of-network: 50%	In-network: 90% Out-of-network: 50%	With \$1,500 deductible PPO: 60% Non PPO: 50% With \$1,000 and \$750 deductible PPO: 70% Non PPO: 55%	Plan pays 90% of allowable fee Member pays 10%

**Health Insurance Plans
Summary**

Health Insurance Plans	Insure MT Premier Plan	Insure MT Standard Plan	Montana State Employee	SEIU 775 Plan D Premiera PPO Plan	SEIU 775 Plan B Premiera PPO Plan	Allegiance	New West Illustrative Quote
Out of pocket amount	\$2,500 individual \$5,000 Family	\$3,500 individual \$7,000 Family	Average of \$2,500 individual Average of \$5,000 family	In-network: \$1,000 Ind / \$3,000 family Out-of-network: none	In-network: \$1,000 Ind / \$3,000 family Out-of-network: none	PPO: \$1,500 Individual Family- two times out-of-pocket per insured Non-PPO: Same as PPO	\$2,500 Individual \$5,000 Family
Preventive health Benefit	Paid at 75%.	Paid at 60%.	Paid at 75%.	Covered in full in-network; no coverage out-of-network	Covered in full in-network; no coverage out-of-network	100% of the maximum eligible expense of the first \$250 deductible is waived	\$20 Co-payment for preventive physical exam.
Office visits	First two office visits per member paid at 100%	First two office visits per member paid at 100%		In-network: \$15 copay, then 80% Out-of-network: 50%	In-network: \$10 copay, then 90% Out-of-network: 50%	Deductible and benefit percentage apply	Subject to deductible and co-insurance
Cost per month	Member \$346 Member and spouse \$692 Member and family \$899		Member \$557 Member and spouse \$762 Member and children \$662 Member and family \$776	Rates effective 8/1/07 through 7/31/08 for Medical/RX, Vision and Dental: Member \$470.26 Member and spouse \$957.86 Member and children \$831.23 Member and family \$1,317.76	Rates effective 8/1/07 through 7/31/08 for Medical/RX, Vision and Dental: Member \$549 Member and spouse \$1,105.43 Member and children \$959.13 Member and family \$1,514.50		Member \$469 Member and spouse \$698 Member and children \$558 Member and family \$908

**Health Insurance Plans
Summary**

Prescription Drug Plan	Insure MT Premier and Standard	Montana State Employees	SEIU 775 Plan D and Plan B	Allegiance	New West Illustrative Quote
Deductible	\$100 per family member	Retail Pharmacy: \$100/member and \$300/family Mail order: \$0	None	\$10 generic \$30 Preferred brand \$60 non-preferred brand	\$200 deductible then copays- \$20 Generic \$40 Formulary \$60 Brand non-formulary
Out-of-pocket max		Per prescription \$250 Per member \$1,400/yr Per family \$2,800/year	None		
Cost per month	Included in health plan	Included in health plan	Included in health plan		Included in health plan

Dental Plan	Insure MT Premier and Standard	Montana State Employees	SEIU 775 Plan D and Plan B	New West Illustrative Quote
Deductible		\$50/member \$150/family	\$50 Individual \$150 Family	\$50/member/ per year
Out of pocket max	\$1000 per member	\$1200 per member	None	\$1000 maximum benefit
Cost per month	Included in health plan	Member \$31 Member and spouse \$47.50 Member and children \$46 Member and family \$53.20	Included in health plan	Member \$33 Member and spouse \$67 Member and children \$62 Member and family \$87